COVENTRY
*Health Care*

# Coventry Health Care of Nebraska, Inc

## Group Enrollment Form

1. Please print or type all necessary information. DO NOT WRITE IN SHADED AREAS.
2. Complete all items requested.
3. NEW MEMBERS: Complete all items in Sections B, C, D, and E.
4. CURRENT MEMBERS: Check all items you wish to change in Section A. Complete Section B with your name and social security number. Fill in Sections C, D, and E with updated information.
5. ALL MEMBERS: Complete pink copy & retain as Temporary I.D. Card for use until permanent card arrives.

**Office Use Only**

Group No. _____ Subscriber No.: _____ Effective Date: _____

Pharmacy Code: _____ Benefit Code: _____

### Section A

Check all that apply:
_____ Name Change
_____ Address Change
_____ Telephone Change
_____ Change Primary Care Physician
_____ Pharmacy Change
_____ Card Correction

Add Dependent(s):_____(date)
_____ Marriage
_____ Newborn
_____ Adoption
_____ Legal Guardianship
_____ Other

Cancel Dependent(s) only____(date)
_____ Marriage
_____ Divorce
_____ Age Limit
_____ Other

Cancel All Coverage_____(date)
_____ Terminate Employment
_____ Voluntary Withdrawal
_____ Leave/Layoff
_____ Out of Service Area Move
_____ Other
Continuation_____ (date)
Conversion_____ (date)

Cobra_____(date)
_____ Death
_____ Termination
_____ Reduction in work hours
_____ Divorce/Separation
_____ Medicare Eligible
_____ Loss of Dependent Eligibility
_____ Retirement

Reinstatement_____(date)
_____ Return from layoff
_____ Return from leave
_____ Rehire
_____ Disenrollment error
_____ Other

### Section B

Last Name | First Name | Middle Initial | Social Security #

### Section C

Address (Number, Street, Apartment) | City | State | ZIP Code | Home Tel. No.

Date of Hire | Employer Name, Location | Work Tel. No.

### Section D

Please indicate your pharmacy selection

### Section E

Please select a Primary Care Physician for you and your dependents before submitting this application.

| Last Name, First Name, MI. | Member No. | Birthdate Mo/Day/Yr | Sex M/F | Social Security No. | Other Health Insurance Including Medicare | CHC Subscriber No. | Primary Care Physician | Primary Care Physician No. |
|---|---|---|---|---|---|---|---|---|
| Subscriber | 01 | | | | | | | |
| Spouse | 02 | | | | | | | |
| Child | | | | | | | | |
| Child | | | | | | | | |
| Child | | | | | | | | |
| Child | | | | | | | | |
| Child | | | | | | | | |

I am applying for covered services for which I and my family dependents are eligible under the CHC Group Membership Agreement with my employer. I authorize my employer to deduct from my earnings the amount required.

All information on this form is true and correct to the best of my knowledge.

I agree on behalf of myself and my family dependents to abide by the terms of the agreement describing my Coverage. I authorize any provider who provides services to me or my family dependents to release to CHC and its participating providers any information or medical records relating to those services. I will complete and sign any documents necessary for the CHC to assume my or my family dependent's legal rights to collect from a third party any costs the CHC incurred.

I also undestand that the CHC Membership Agreement contains a provision which obligates me to follow a complaint procedure or any claim or disputes regarding Coverage.

Employee Signature _____ / Date

Employer Representative Signature (in Employee absence) _____ / Date